The Hampden Hippocrat April 1972

on Tuesday

APRIL 25, 1972

Annual Meeting!

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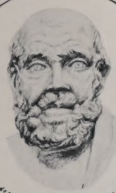

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A bulletin for
The Hampden District of
The Massachusetts
Medical Society

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Editorial . . .

A CREDITABLE UMBRELLA?

Believing that change in health care delivery is necessary and indeed, inevitable, the leadership of the American Hospital Association envisions this organization as becoming the creditable "umbrella" organization for formulating and implementing an effective all-out attack on this nation's health care problems. As hospital leaders see it, hospitals can no longer be just repositories for the sick and just concerned with what goes on within their own walls: Since the "right" to health care has become "an established national principle" and the demand for health services is in ever growing demand, hospitals feel that they are under pressure to provide same because of "their community commitment". Moreover, hospitals with their capacity to provide a full scope of health services and their embracement of nearly all those who provide health services (including physicians) feel that they can mount a formidable attack.

Mr. Stephen M. Morris, the new President of the American Hospital Association and the President of the Good Samaritan Health Service of Phoenix, Ariz., in his inaugural address at the annual meeting of the AHA, which was held in Washington, D.C., last February, put it most succinctly when he said:

"The hospital's enormous pool of management talent and its stable financial base assure the potential for becoming the health care catalyst and innovator. All that is required is courageous and enlightened leadership to blend the multiplicity of talents within the institution into a constructive and effective force. Never before has the potential or the need for leadership been so up for grabs."

THE KEY

The key to "grabbing" this leadership is the collaboration of physicians. Hospital leaders believe that this can readily be attained because medical practice is becoming more and more institutionalized and physicians are becoming increasingly commited to hospitals. Hence, the approach envisioned is through a basic and already organized unit, namely, the hospital medical staff. It is believed that physician participation in an organization such as the AHA would be more representative and meaningful by virtue of its being based on a unit where physicians of all kinds come together in a close working relationship rather than on the basis of geographical boundaries or narrow interests of specialty societies. Pulling hospital medical staffs into one national organization is seen as creating a body of physicians even greater than the AMA for hospital medical staffs include many who are not in the AMA – house officers, medical school faculty members, full-time physicians, and many other physicians who have opted to stay out. Moreover, many of the latter mentioned exert tremendous influence on hospital medical staffs.

To sweeten the inducement, hospital leaders are striving to develop a new working partnership between medical staffs, trustees, and the management of hospitals. Already the AHA has approved in principle physician membership on hospital

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governing boards and board committees. Ways are being sought to involve physicians in meaningful management activities, for here is "where the action is". Management is pictured as the "innovator, the creator of new policies, programs, and services," which the governing board passes upon. Greater house officer participation is envisioned with interns and residents becoming members of all medical staff committees. To top it all, direct membership of hospitals in the national organization is available so that anybody with leadership potential can rise rapidly in the hierarchy and not be necessarily bound by constituent state and local organizational commitments or have to move up through the screening rungs of local and state organizational activities. Where better could hospital medical staff leaders find a place for their voices to be heard?

OBSTACLE

Although physicians are already organized as hospital medical staffs, there is still the obstacle of linking each specific and separate hospital group into working together for a common cause. Each hospital's medical staff zealously guards, supports, and seeks to enlarge its own privileges, prerogatives, and status within and for its mother institution. Can this sectarianism, which is prevalent throughout the entire hospital's organization, be overcome? Can staffs of separate hospitals be drawn together for the common good on the local level to say nothing of the national level? Not as long as competition is considered an essential ingredient for progress! And this fundamental principle is highly espoused by many in and out of the health care field.

WHICH WILL IT BE?

The glove seemingly is being cast down. Will the hospitals and the AHA "grab" the sceptre of regency for American medicine and lead the vanguard in a noble crusade of solving this nation's health care problems? Presumably the AMA with its constituent state and local societies is the organization to be deposed; hence, what will its reaction be? Or, will there yet be some other undreamed of organization conceived to assume this coveted mantle of leadership? Of course, the spectre of government take-over is always projected as an alternative. Despite the furor over who is or is not going to be number one, hospital leaders acknowledge the inescapable reality that physician collaboration and leadership are the sine qua non for any endeavor destined to work with this nation's health problems. With this in mind, each physician must reflect deeply where he will cast his loyalties and talents. Enticements, overt and subtle, will be proffered by many forces. To hitch one's wagon to hospitals, the traditional spawning grounds and familiarly comfortable workshops of physicians, may appear most alluring. However, let it not be forgotten that in unity there is strength. Division and dilution can only weaken. If the vehicle of physician unity has some faults, then the solution is not necessarily to discard same and attempt to find it in another vehicle which may already be faulty and weak because of various divisions and dilutions. It would be far better for physicians to modify, improve, and strengthen their existing vehicle of unity, for one's own umbrella is far more salutary than a piece of one shared with many others.

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MANY HAPPY RETURNS!

This year marks the 30th anniversary of *The Hampden Hippocrat.*

Today we take our bulletin more or less for granted but its birth in 1942 was surrounded by an atmosphere of spirited debate and controversy. Many relevant questions were posed by the membership: Is the Hampden District really in need of a bulletin? Is it feasible? How will it be financed? Etc., etc. Incredible as it may sound, it was World War II that finally tipped the scales in its favor. A District bulletin, the co-sponsors argued, would serve to keep our colleagues in uniform posted on what was happening back home. The co-sponsors, who subsequently became the co-founders, were the late Drs. Edward P. Bagg and W. A. R. Chapin.

Following the homecoming of our veterans, *The Hampden Hippocrat* ipso facto ceased being a "War" bulletin. Instead it turned its undivided attention to the home front, publicizing as much as possible the Society's meetings, programs, committee reports, etc. This endeavor proved only partially successful since *The Hampden Hippocrat* appeared then only on a quarterly basis. Thus, meeting notices often had to be published either months in advance or not at all. Moreover, the bulletin at that time counted not more than 16 pages, hardly enough to be effective or meaningful.

COME THE 1950's

The demands on *The Hampden Hippocrat* increased even further in the 1950's when our Society's activities, for one reason or another, skyrocketed above all expectations. To meet these newer demands, *The Hampden Hippocrat* made a number of significant changes in its format and structure. Thus, it increased the size of its Board of Editors, it doubled the pages per issue, and in 1956 began to appear on a monthly basis (except for July and August). Since then *The Hampden Hippocrat* has averaged 28 to 36 pages. The sole exception was the 56-page issue of January, 1965, dedicated to our Society's 125th Anniversary. This issue incidentally, promises to become a veritable treasure of reference material for the historians of the future.

The Hampden Hippocrat may mean different things to different people but to the Board of Editors it means many, many things, most of which are interrelated. We quote from this column of several years ago (April, 1968):

"Hampden's recent success is due, in part at least, to the many services rendered by its bulletin. What are some of these services? (1) It keeps the membership informed; (2) it stimulates interest in Society affairs; (3) it encourages meeting attendance and committee participation; (4) it improves internal relations; (5) it affords the members an opportunity to express their views, opinions and ideas; (6) it chronicles significant events; and finally (7) it forms yet another link of communication between Hampden and its parent organizations. Copies of our bulletin are mailed regularly to 22 The Fenway, Boston and to the AMA in Chicago."

For a medical bulletin to survive 30 years is exceptional these days; to do so without expense to its Society is unheard of. Just how much longer *The Hampden Hippocrat* can remain self-sufficient is difficult to tell. Publication costs are soaring while income from advertising is steadily declining. A time may indeed come when our

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bulletin will have to be subsidized to a greater or lesser degree. If and when that time comes, our Society, hopefully, will not hesitate to lend a helping hand. Over the years *The Hampden Hippocrat,* as suggested earlier, has proved itself invaluable in more ways than one. Hampden District without *The Hampden Hippocrat* now seems unthinkable.

PLEASE WRITE!

And so, on this its 30th birthday the least we can do is to salute *The Hampden Hippocrat* and to dedicate ourselves toward its continued success and progress. We may begin by reading it regularly; if possible, from cover to cover. Ours, in the opinion of many, is a well rounded District bulletin packed with pertinent and informative material. Besides, there is the old saying that "A publication that's not read isn't worth the paper its written on." Next, we might get into the habit of patronizing our advertisers and mentioning, of course, that we saw it in *The Hampden Hippocrat.*

Finally, what would please *The Hampden Hippocrat* most of all is to receive from the membership more letters, comments, opinions, remarks, criticisms, etc. Over the years many items of this type have reached the Editor's desk, but hardly enough. With so many ethical and socio-economic problems confronting us, the opinion of every member counts. What do you think of Foundations? Of the proposed health insurance plans? The AMA? The Blue Shield? Medicare? Peer reviews? *The Hampden Hippocrat* invites you to express yourself freely on these and other relevant matters. From its very beginning our publication has made it clear that it was not only a news bulletin but also a sounding board. The attitude of *The Hampden Hippocrat* in this respect has changed not at all. In fact, now more than ever, it is not only anxious that you read what's in it but would very much like to have you become part of it.

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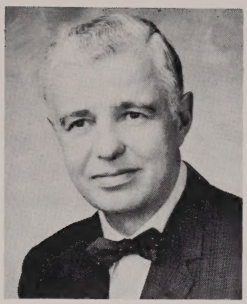

President's Page

OUR ANSWER

One year ago, in my inaugural address, I began with this statement: "we are confronted with the ever increasing demand for compulsory health insurance of one form or another." This demand with its variations is even greater today. Parallel with the advent of compulsory health insurance is the peer review mechanism sponsored by Senator Bennett. Two months ago the Senator's "Professional Standards Review Organization" (PSRO) amendment to the Social Security Bill was passed by an 8-1 vote through the Senate Finance Committee. It seems certain to become law this year.

Attacking us more directly, the health insurance carriers are trying to establish our fees according to their "usual and customary" payments. The "Blues" as well as the private health insurers have taken independent but similar actions. Blue Cross-Blue Shield announced the other day, via the newspapers, that they are about to institute their so called "Level of Claims Review Program". The intent of this program is, for some committee in a remote place, probably Chicago, many months after the patient has gone home, to make retroactive decisions as to payment of claims. Such retroactive denials of medical payments are now pending in courts in Pennsylvania.

Emulating the "Blues", but without benefit of the medical society sponsorship, there has emerged during the past 10 months, still another and a more direct attack by the private insurance carriers. Many of us in this district have received copies of letters sent to our patients by private insurance carriers. These letters state a variation of this theme – "We have examined your claim and have determined that $ . . . . . of the charges for medical services by Dr. . . . . is the amount we may properly include as covered expenses. If you decide not to pay the difference between the full charge (that the physician made) and the amount we have determined to be covered expense, you may wish to notify your physician of our determination . . . . . ." The implication is clear that the insurance company determines what the "usual and customary fee" is by feeding into their computers the fees that they choose to pay the physician. The Blue Shield method of determining our "usual and customary" fee is more sophisticated but the end result is the same. What the individual physician charges as his usual and customary fee is utterly ignored. It was bad enough for Blue Shield to set up a unilateral fee schedule, now the private carriers are trying to do the same thing.

Even though physicians receive less than 15% of the health dollar spent in this country, they are the ones who order or direct the expenditure of the remaining 85%

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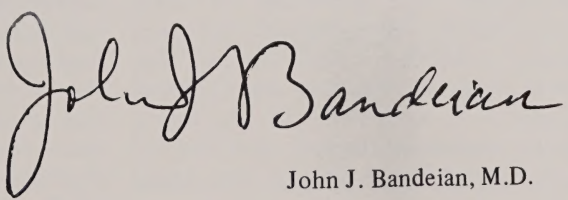
of the health dollar. It is, perhaps, for this identity or responsibility that physicians have been attacked by so many groups of people during these past 20 years. Individually, and even as an organized professional society such as the Hampden District Medical Society, the Massachusetts Medical Society or even the American Medical Association, we are sitting ducks to the many snipers. Professional societies by the terms of their charters are unable to bargain the terms for the practice of medicine. But, incorporated as a foundation for medical care, physicians in many areas have been able to enter into contract with insurance carriers to provide maximum quality medical care at a reasonable cost. The fee schedule is not set arbitrarily by the insurance carrier but it is arrived at in consultation with the foundation. It is computed utilizing the Massachusetts Relative Value Study and a uniform conversion factor. Furthermore, such conversion factors for each specialty are renegotiated annually.

A foundation for medical care offers us a viable mechanism for the survival of the practice of medicine on a fee for service basis, and our cherished patient-physician privacy. Such a foundation provides us with a means of protecting our economic interest. Through negotiation with third party payers, private or government, it can assure adequate compensation for its members. Interestingly enough, both the Health, Education and Welfare Department as well as the private health industry see in the foundation for medical care a method of overcoming the spiraling medical costs. They have expressed their interest in foundations.

A foundation for medical care consists of a group of physicians from this and/or adjoining district medical societies, incorporated, and dedicated to provide for our community a means of stabilizing the health care costs. At the same time a foundation for medical care assures our community a maximal quality of medical care to all who seek medical care. It assures the physicians leadership in the administration and in the practice of medicine. A foundation for medical care can assure to the third party payer, both private and government, a means of controlling costs through peer review mechanisms.

Let us, one and all join the Medical Foundation of Western Massachusetts, Inc., a creation of the Hampden District Medical Society.



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UNIONISM OR UNAMITY

The suddenly renewed interest in a physician's union demands not so much that we agitate for physical organization but that we reflect inwardly and ask ourselves why this once so noble a profession has reached a point where it seriously considers emulating tactics and methods we traditionally have openly condemned. Why the descent downward? Would it improve our already badly tarnished image? Has our percentage of success in the political arena been so high in recent years that we would welcome yet another similar encounter with naught but similar results? How long will it take before we clearly appreciate that where we once were considered as men of the highest integrity and thought to be completely trustworthy, we now are thought of as being selfish and even dishonest as most everyone else.

After completing 15 years of government service and a little over fifteen years of private practice, I know how false this image really is. There is no question in my mind that the medical profession, by comparison with all other trades and professions, contains a remarkably high percentage of truly dedicated and compassionate men and women. I would not deny, however, that there are a few charletans and dishonest members in our group, and like rotten apples in a barrel, they are most evident, and devalue the worth of the whole group.

LESSONS TO BE LEARNED

Returning for the moment to the question of unions and political tactics, may I relate an incident that contains considerable meaning.

Approximately one year ago, April 1971, the American College of Surgeons held one of it's sectional meetings in Montreal and invited Dr. MacGreagor, Dean of the medical faculty of McGill University, to be its guest speaker. After presenting the developments in Quebec, which is recent history to all of us, and explaining in considerable detail how the medical fraternity "organized" for a show-down with the government, and after reviewing for us the results of this "show-down", he then said to us as nearly as I can recall his words:

"I am certain you medical colleagues from the United States are wondering if I have any advice I can give you, since in many respects, your developing problems are similar to ours. Yes, I have one thing I would like to suggest and that is this. Do not establish or allow to develop a direct confrontation between you and the government, which is really the elected representatives of the people. If you do, I feel quite certain you will lose. Rather than a militant confrontation, I suggest you continue with discussions, regardless how irksome or fruitless they appear at times. The advice and counsel we as physicians give will contribute much to a finally improved and better plan. But if

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plans are made without the assistance of the medical fraternity, and they will be so done if necessary, the public will lose by such action, but the physicians will lose the most."

Let us remind ourselves that raising our fees for our services is not the question at all. It is rather a question of whether the fee-for-service concept will prevail. And the true reason for maintaining this concept is not based on its value to the physician, but rather, it is necessary because it is so deeply a part of the patient-physician relationahip and is the factor by which the physician serves his patients above all else. Without this relationship the patient's welfare is bound to suffer.

In these difficult times we must discipline ourselves to practice an ever higher standard of practice and conduct. The profit motive must remain secondary. A physician who never rejects a patient in need will in turn never be rejected. Good public relations, as always, must be earned by devotion to our profession. I am certain that most physicians abhor the tactics of the market place, especially on an individual level.

SPHERE OF INFLUENCE

While so many of our patients are trying to eat, drink, or smoke themselves to death, we must be compassionate and yet, at the same time, by our example, deserve their trust and respect.

There are strong forces favoring the abolishment of private practice and replacing it with health service systems which would be regulated and subsidized. How successful that movement becomes will depend to a great extent on the role each of us plays individually within our own sphere of influence.

I am not suggesting that there is no value to organizing our resources or our manpower. Far from it. Our future way of life, our enjoyment in our work, our privacy in our relationship with our patients, will truly depend on our ability to organize. Our future peer review functions, both within and outside the hospitals, will depend on how well we have organized ourselves in approaching the PSRO function which will soon be legally upon us. The foundation concept, and particularly the honest and unselfish application of the relative value guide principle with a fair and adjustable conversion factor controlled by our peers and parent specialty or society organizations will offer us a chance to practice our professional duties without much time and effort being needlessly devoted to fiscal arguments. And who can deny that by this one change alone our so-called image may shine somewhat brighter.

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THE MEDICO-LEGAL CODE FOR HAMPDEN COUNTY

(Editor's Note – The following code was developed by a joint committee on medico-legal affairs consisting of representatives from the HDMS and the Hampden County Bar Association. It was approved by the Executive Committee of the HDMS on March 21, 1972, and will be presented to the membership of the HDMS for adoption at the latter's annual meeting, which is to be held on April 25, 1972.)

PREAMBLE

Acknowledging that a substantial part of the practice of law and medicine is concerned with the problems of persons who require the services of a lawyer, physician, and hospital; and that the public interest requires that those situations be covered by a standardized procedure for all concerned; we, the members of the Hampden County Bar Association and The Hampden District Medical Society, do adopt the following principles as standards of proper conduct for lawyers and physicians, subject always to rules of law and standards of legal and medical ethics prescribed for our individual conduct.

I – MEDICAL REPORTS:

A – The request for a report from a physician shall be on the annexed authorization form.

B – The report will be submitted by the physician to the lawyer within thirty (30) days of receipt of the request or upon completion of treatment.

C – In those cases where the physician is the attending physician, if the request for the report is received while the patient is still being treated or soon after treatment is completed, the charge made by the physician for the report shall be commensurate for the time in preparing such report.

D – If the physician is not the attending physician but has examined the patient at the request of the lawyer, the charge for the examination and report will be a reasonable one.

E – The responsibility for paying for the report shall be that of the lawyer, and payment shall be made to the physician upon receipt of the same or within thirty (30) days.

II – PRE-TRIAL CONSULTATIONS:

A – Pre-trial consultations between the lawyer and physicians shall be arranged at their mutual convenience.

B – The physician shall be entitled to make a reasonable charge for the consultation; and the payment of the charge shall be the responsibility of the lawyer. The charge will be paid when the case is closed regardless of the outcome of the same.

III – COURT APPEARANCES:

A – The lawyer will give the physician as much notice as possible as to the time at which the physician will be required to be in court to testify; and when a time is determined, the physician will be present.

B – The physician will be entitled to reasonable compensation for his time in court; and, if possible, the amount of compensation will be determined by the lawyer and physician prior to the appearance of the physician in court. Once the physician has set a time for appearance and if the case is settled immediately before appearance, the physician will be compensated unless notified twenty-four (24) hours ahead.

C – It shall be the lawyer's responsibility to pay the reasonable compensation charged by the physician for his court appearance. The compensation will be paid when the case is closed regardless of the outcome of the same.

IV – DEPOSITIONS:

A – A physician shall receive from the lawyer the same notice, courtesy, and compensation for testifying at a deposition hearing as the physician is

entitled to receive for testifying in court.

B – It shall be the lawyer's responsibility to pay the reasonable compensation charged by the physician for testifying at the deposition hearing; and it shall be paid when the case is closed regardless of the outcome of the same.

V – CHARGES FOR MEDICAL TREATMENT:

A – The physician's charges for rendering medical care to the patient-client shall be solely the responsibility of the patient-client and not that of the lawyer.

B – The physician, in cases of hardship, will postpone efforts to collect his bill for medical care if he has received an executed authorization form (in the form annexed) from a lawyer. However, the lawyer will advise his client that the physician's bill should be paid promptly if the client has funds to do so; and that the courtesy of the physician in not pressing for payment pending the resolution of the law case does not warrant an otherwise solvent client from delaying payment of the bill until the case is closed.

C – The lawyer, upon receipt of the bill for treatment from the physician, shall pay the bill from the proceeds recovered in the bodily injury case before disbursement is made to the client.

D – The term "medical care" shall include diagnosis, consultation, and/or treatment.

E – If the lawyer requires a medical bill to be in the form prescribed by *General Laws, Chapter 233, Section 79G,* and the bill submitted by the physician is not in that form, the lawyer shall prepare the bill in proper form and submit it to the physician who shall subscribe it and return it promptly.

VI – LAWYER'S OBLIGATION FOR COSTS:

A – Insofar as this code imposes an obligation on a lawyer to pay for certain services of a physician, the obligation shall also be that of the client.

B – It is the lawyer's responsibility to obtain from the client reimbursement for any charges paid by the lawyer pursuant to this code.

C – If a lawyer is discharged from a case or withdraws from a case before it is closed, he shall then pay all charges which he would otherwise be required to pay when the case is closed, and he shall promptly notify all physicians who have rendered reports to him of his withdrawal from the case.

APPENDIX

MEDICAL REPORT AUTHORIZATION FORM

To: Dr. . . . . .

Re: Accident Date: . . . . . .

I hereby authorize you to furnish to my attorney, namely: . . . . . , but to no other person, any reports he may request concerning the injury sustained by me, my wife, and/or my child or children in the above accident.

I hereby authorize and direct my attorney to pay you from the proceeds of any recovery in the case arising from said accident and pertaining to said injuries, your bill for professional services in rendering medical diagnosis and treatment and your charges for furnishing reports, consultations, deposition, and court appearances in conformity with the Medico-Legal Code.

I understand that this authorization in no way relieves me of my personal responsibility for paying for said charges. I understand that you will comply with this request for a report within a reasonable period of time.

. . . . . Patient

Address: . . . . . .

. . . . . .

I hereby acknowledge receipt of the above authorization.

. . . . . Attorney

Date: . . . . . .

SPRINGFIELD'S MORTALITY STATS

An unofficial analysis of death certificates filed in the City of Springfield for residents thereof in 1971 reveals that a total of 1,644 persons died during the year. This figure does not include those Springfield residents who died outside of the City nor the 921 deaths of non-residents occurring in the City.

TEN LEADING CAUSES OF DEATH

1. Diseases of the heart	639
2. Neoplasms	281
3. Cerebrovascular lesions	243
4. Pneumonia (all types)	99
5. Accidents	80
6. Cirrhosis of liver	45
7. Diseases of early infancy (under 4 weeks of life)	42
8. Diseases of circulatory system	37
9. Bronchitis	34
10. Gastritis	25
All other causes	119
Total	1,644

Deaths from heart disease lead the list with 38.9% of all deaths; next, neoplasms with 17.1%; third, cerebrovascular lesions with 14.8%; fourth, pneumonia with 6%; and fifth, accidents with 4.9%. Approximately 3/4 of the deaths occurred in those 60 years of age and above. Males predominated over females in the ratio of 1.04 to 1. The trend, as in the recent past, continues to point out that chronic diseases, particularly those of the cardiovascular system in the older age groups are the major killers of Springfield residents.

DEATHS FROM INFECTIOUS DISEASES

Pneumonia	99
Bronchitis	34
Meningitis	1
Meningococcal Infection	1
Tuberculosis	1
Septicemia	1
Total	137

Only 3 deaths were due to infectious diseases considered officially dangerous to the public health. Most of the pneumonia and bronchitis were undoubtedly fatal precipitations superimposed on some other debilitating disease process.

Analyzing the 80 deaths occurring to 41 men and 39 women as the result of accidents, the following interesting facts present themselves. First, 43 or more than 1/2 occurred in or about the home as the result of falls involving 14 men and 29 women primarily in the older age groups. Secondly, 16 persons were killed as the result of traffic accidents – 2 drivers, 2 passengers, 10 pedestrians, 1 motorcyclist, and 1 bicyclist. Nine died as the result of fire and 1 drowned. Five deaths occurred as the result of narcotic drug overdosage and 1 death respectively as the result of being caught in a drill press, being caught under a load of steel, exposure to cold, hot water burns (in a bath tub), ingestion of alcohol while under antabuse therapy, and a ricocheting bullet.

From a mental health point of view, it might be pointed out that there were 13 suicides (7 male and 6 female) with deaths beginning in the teenage group, peaking in the 30-50 age group, and continuing to 80 and above. Moreover, there were 14 homicidal deaths (8 male and 6 female).

There was one death resulting from complications of pregnancy, and 29 stillbirths were reported. Fifty-seven infants (under 1 year of age) died with 42 of these under 4 weeks of life. In addition, 4 died of diseases of the circulatory system, 2 due to pneumonia, 2 due to congenital malformations, 2 due to accidents, 1 due to Reyes Syndrome, 1 due to homicide, 1 due to ill-defined causes, 1 due to gastritis, and 1 due to septicemia.

Ayres

HDMS COMMITTEES ANNUAL REPORTS 1971-1972

THE SECRETARY

Not only by day, but almost every night, the midnight oil burns at 1414 State Street, the headquarters of your society. Your chosen officers, some 20 committees, invariably meet to keep you informed of the various activities, not only in medicine but legislation and hospital planning within our county and throughout the state. Perhaps, the single most important accomplishment of this year was the acceptance of our society to proceed with the establishment of a Foundation for Medical Care. From the very beginning of his presidency, Dr. John Bandeian pursued this concept. Dr. Robert LaMarche was given the difficult task to chair this committee after the preliminary and effective beginnings brought about by Dr. Howard Simpson. Dr. Robert LaMarche and his committee spent literally hundreds of hours including travel time to present all sides of this new institution. They are to be congratulated for their fine work.

The annual reports of the various committee chairmen are herewith published. Their short reports in no way attests to the tireless hours that they and their committee have put in after office hours, in the evening, and also traveling to Boston to state meetings to represent our local society.

Our attendance at quarterly meetings has been quite satisfactory and we had the good fortune to have at our February meeting, Dr. Wesley Hall, President of the AMA.

During the past year 29 physicians have joined the Society, 2 have resigned, and 8 have transferred from the Society. Twelve have passed from our midst. Our present membership stands at 518, of which 76 are senior members.

Mrs. Vivian Purdy has served as our Executive Secretary for over one decade. I have worked with her as early as 6:30 in the morning and as late as 11 P.M. She does her work earnestly and cheerfully, and without her assistance I could not possibly carry out my task as well. I appreciate her help as well as Mrs. Alicia Willard and my own assistant secretary, Dr. Rocco Verrilli for "pinch hitting" throughout the year.

Setrag A. Zacarian, M.D.,
Secretary

EXECUTIVE-GRIEVANCE COMMITTEE

The Executive-Grievance Committee of the Society has met monthly during the past year except for July and August. During the past year, 36 written grievances against members were received from patients, third party payees and other physicians. Most of these grievances are resolved by the Executive Committee, and with rare exceptions does the need arise to forward any to the Ethics and Discipline Committee of the Massachusetts Medical Society. Under the able chairmanship of Dr. Bruce Stoler of the Peer Review Committee, we have forwarded several third party payment complaints and irregularities in fees for this committee's review. This committee is representative of every specialty group and will serve an important role with the establishment of Foundations for Medical Care.

Setrag A. Zacarian, M.D.,
Secretary

AD HOC FOUNDATION FOR MEDICAL CARE COMMITTEE

This is a report of the Ad Hoc Foundation for Medical Care Committee. This ad hoc committee met weekly, and had many meetings, as reported in *The Hampden Hippocrat,* with Mr. Louis Orsini, Dr. Piffat and Mr. Zivot. A recent meeting took place with Dr. Fine and the Mass. Blue Cross and the Mass. Blue Shield. The Committee formulated its work as it was originally asked to do at the Society's October, 1971, meeting. A "blueprint" was presented to the Society on February 1, 1972. This report was passed with only one dissenting vote. The Society went on record as advising the Ad Hoc Committee to go ahead and formulate bylaws and articles of incorporation along the lines of the New Mexico, Colorado type of foundation, which was the middle line of the prospectus drawn up and given to the Society on February 1, 1972.

The bylaws are being worked on very nicely in conjunction with Mr. Steve Reimer, our attorney. At the last meeting of the committee on March 24, Dr. LaMarche reported on his visit to the

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Medical Association of Georgia and the Fulton County Foundation. Dr. Marsden reported on his discussion with Mr. Gordon concerning the Hartford Foundation. The formulation of the first draft of the bylaws was finished. These will be presented at a meeting to be held on April 3, 1972, so that they will be waiting for completion at that point as anticipated and will be presented to the Society on April 25, 1972.

Robert N. LaMarche, M.D.,
Chairman

BOARD OF EDITORS
"THE HAMPDEN HIPPOCRAT"

The submission of this report marks the completion of thirty years of publication by *The Hampden Hippocrat* on behalf of the HDMS. During 1970-1971, *The Hampden Hippocrat* continued to appear monthly except for July and August with all issues consisting of 32 pages except for the March issue, which consisted of 40 pages, featured AMPAC and BAYPAC, and was sent to all members of the MMS. In publishing the latter issue, financial support was garnered from a variety of sources with stimulus from Dr. James D. Allan, Chairman of BAYPAC. *The Hampden Hippocrat* has made every effort to present various views on such local, state, and national issues and developments as health quackery, HMO's, Foundations for Medical Care, and legislation. The traditional "special theme" issues included the Woman's Auxiliary, religion and ethics, legislation, and political action. It was most flattering to have an editorial quote again in the *American Medical News* during the past year.

High praise and gratitude are certainly in order not only for all members of the Board of Editors but also for the HDMS officers, committee chairmen and their respective committee members as well as specially invited contributors. *The Hampden Hippocrat* is a bulletin for and of each member of the HDMS; hence, we implore you to communicate your ideas, views, suggestions, questions, criticisms, and complaints.

Financially, *The Hampden Hippocrat* had to tap its reserves for the fifth year in a row but not quite as deeply as in the past. Inflation still continues to outstrip all out efforts to keep up with receipts from advertising. Financial reserves continue to dwindle. Subsidy from HDMS is still not looked upon with favor by the Board of Editors. Rather, increased advertising with each member of HDMS selling *The Hampden Hippocrat* to potential advertisers would be preferable. Assistance is readily available from Mrs. Arthur Willard, our Advertising Director. Help us to help you!

Indebtedness to many is a way of life for *The Hampden Hippocrat*. To single out individuals for thanks can be running the risk of slight; on the other hand, thanking each individually is impossible. Therefore, to each and all, our deepest and sincerest gratitude is hereby extended.

John C. Ayres, M.D.
Editor-in-Chief

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BY-LAWS COMMITTEE

The By-laws Committee was asked to consider lowering the number of members necessary for a quorum from fifty to twenty-five. Committee members were unanimous in recommending to the Executive Committee that the by-law not be changed.

No other business came before the Committee.

Harry N. Memery, M.D.,
Chairman

DISASTER MEDICAL CARE COMMITTEE

During the past year the Disaster Medical Care Committee has met at intervals. This committee has been composed of the chairmen of the Disaster Committee of the various hospitals in the area.

An attempt has been made during this year to be sure that each individual hospital disaster plan has been brought up to date. The Committee has included, as guests for its meeting, representatives of the Springfield Police, Fire and Civil Defense Departments. It is anticipated that a new era of cooperation, between the involved agencies and the HDMS, will better improve our public relations image and allow us to be in a position to handle, efficiently, any disaster, large or small, should it occur within this community.

Frederick C. Schwendenmann, M.D.,
Chairman

INSURANCE, LABOR RELATIONS AND INDUSTRIAL ACCIDENTS COMMITTEE

This past year has seen increased activity of the Insurance Labor Relations and Industrial Accidents Committee directed towards presenting unauthorized activities of insurance carriers. This past year, the Committee has dealt mainly with the Connecticut General Life Insurance Company who have persisted in directing statements to patients of physicians in our district, informing them of a "reasonable and customary" fee scale. Such statements have been accompanied with the implication that doctors who do not subscribe to Connecticut General's fee scale are imposing "unreasonable" fees.

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To date, Connecticut General has not accepted the Massachusetts Relative Value Study nor any mutually agreed conversion factors. Efforts are proceeding now on the State level with this committee in order to employ legal methods if possible to insure that this practice ceases, until such time as a mutually agreed fee scale has been effected.

Although this process is a slow one, we look forward to success in the forthcoming year.

Richard Clark Hirschhorn, M.D.,
Chairman

INTERHOSPITAL AND COMMUNITY HEALTH PLANNING COMMITTEE

The Interhospital Committee and Community Health Planning Committee met just once during this past year. At that time it was to answer some questions from the Peer Review Committee. These were answered, and forwarded to the latter.

In view of the fact that there was considerable work being done on the Foundation for Medical Care and the Peer Review Committee, it was felt that much of the work which was carried on by the Interhospital and Community Health Planning Committee was being done by the latter committees and could be completed by same. Since there would be duplication of efforts by the Interhospital and Community Health, it was felt that this should be foregone until the other work was completed.

In view of the fact that the Foundation of Medical Care Committee would enter into contractual obligations with hospitals and the insurance companies, it was felt that representation from the latter would be placed on the Foundation Committee and that communications could be carried out thereby. In view of this, it was felt best, perhaps, that this particular committee, because of the overlapping work involved, would be best replaced by continuing to have the Foundation for Health Care and the Peer Review Committees carry out the work of communication between the Society and the hospitals. It was thought that this committee could well be eliminated, and a suggestion is to be so made that the Interhospital and Community Health Planning Committee be eliminated and be replaced by the Peer Review Committee and the new Foundation for Medical Care. As such, it would be so recommended to the Bylaws Committee.

R. N. LaMarche, M.D.,
Chairman

LEGISLATIVE COMMITTEE

Each calendar year approximately 8,000 bills are filed for consideration by the Great and General Court of the Commonwealth. This presents an overwhelming task for our legislators and often frustrates the Society in its efforts to influence those matters affecting health and medical practice. Those of you who wish further insight into this matter may request a copy of "The Confessions of a Lobbyist" by David M. Kinzer from

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191st Anniversary Meeting
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STATLER HILTON, BOSTON
May 30, 31, and June 1, 1972

TUESDAY, MAY 30
RESPIRATORY INFECTIONS
Moderator:
Arnold N. Weinberg, M.D., Boston

8:30 *Approach to Diagnosis in Infiltrative Lung Disease.* Arnold N. Weinberg, M.D.
8:45 *Bacterial Pneumonias.* Morton N. Swartz, M.D., Boston
9:00 *Nosocomial Pulmonary Infections.* David Feingold, M.D., Boston
9:15 *Mycoplasma in Pulmonary Disease.* Jerome O. Klein, M.D., Boston
9:30 Q & A

PULMONARY EMPHYSEMA
Moderator:
Gordon L. Snider, M.D., Boston

10:45 *Introduction.* Gordon L. Snider, M.D.
10:50 *Physiological Tests in Diagnosis and Management.* Frank Davidson, M.D., Boston
11:05 *Alpha I Antitrypsin Deficiency in Pulmonary Emphysema.* Jack Lieberman, M.D., California
11:30 *Ambulatory and Home Care of Chronic Obstructive Lung Disease.* Philip Kimbel, M.D., Philadelphia
11:55 Q & A
12:15 Section Luncheons on Allergy, Anesthesiology, Radiology, Internal Medicine, Physical Medicine.

PULMONARY EMBOLISM
Moderator:
James L. Tullis, M.D., Boston

2:15 *Predisposing Factors.* James L. Tullis, M.D., Boston
2:30 *The Clinical Spectrum of Pulmonary Embolism.* Arthur Sassahara, M.D., Boston
2:40 *New Radiological Techniques in Diagnosis.* Ferris J. Siber, M.D., Boston
2:50 *Anticoagulation Therapy.* Daniel Deykin, M.D., Boston
3:00 Q & A

THE PULMONARY RISK SURGICAL PATIENT
Moderator:
Myron Stein, M.D., Pawtucket

4:00 *Assessment of Risk.* Myron Stein, M.D.
4:10 *Pre and Post Operative Sputum Evaluation.* Sanford Chodosh, M.D., Boston
4:20 *The Role of the Anesthesiologist.* Leonard S. Bushnell, M.D., Boston
4:30 *Post Operative Atelectasis.* Edwin J. Kroeker, M.D., Boston
4:40 Q & A

WEDNESDAY, MAY 31
AIR POLLUTION FACTORS IN HUMAN HEALTH
Moderator:
Benjamin G. Ferris, Jr., M.D., Boston

8:30 *Effects of Selected Air Pollutants on Human Health.* Benjamin G. Ferris, Jr., M.D.
8:50 *Effects of Automotive Exhausts on Boston Policemen.* Frank E. Speizer, M.D., Boston
9:10 *The Asbestosis Problem in New England.* Edward A. Gaensler, M.D., Boston
9:30 *Effects of Toluene Di-isocyanate (TDI) on Human Health.* John M. Peters, M.D., Boston
9:50 Q & A
11:00 The Shattuck Lecture. *Will Partisan Politics Determine the Nature and Quality of Health Care?* (An open letter to President Nixon and the Democratic nominee) William George Anlyan, M.D., Duke University
12:00 Section Luncheons on Dermatology, Occupational Health, Obstetrics and Gynecology, Pediatrics, Pathology, General Practice.
2:00 Annual Meeting of the Society.
3:30 Annual Discourse. *Organ Replacement. Facial Deformity and Plastic Surgery.* Joseph E. Murray, M.D., Boston
6:00 Members and Guests Reception
7:00 Annual Dinner. Anne Ramsay Somers, Rutgers Medical School; Princeton University

THURSDAY, JUNE 1
ACUTE RESPIRATORY FAILURE IN THE ADULT
Moderator:
John Hedley-Whyte, M.D., Boston

8:30 *Introduction.* John Hedley-Whyte, M.D.
8:50 *Maintenance of the Circulation.* John J. Skillman, M.D., Boston
9:10 *The Management of Respiration.* Hillary Don, M.D., Boston
9:30 Q & A

SOME CURRENT PULMONARY PROBLEMS
Moderator:
David P. Boyd, M.D., Boston

10:45 *Bronchogenic Carcinoma – Medical Challenge of the 70's.* David P. Boyd, M.D.
11:00 *Surgical Approach to Bronchogenic Carcinoma Today.* Mian M. Ashraf, M.D., Boston
11:15 *Roentgen Therapy in Bronchogenic Carcinoma.* Ferdinand A. Salzman, M.D.
11:30 *Tumor Doubling Times in Metastatic Lung Disease.* Paul Adkins, M.D., Washington, D.C.
11:45 *New Drugs in the Treatment of Pulmonary Tuberculosis.* Samuel Clive Cohen, M.D., Boston
12:00 Q & A
12:15 Section Luncheons on Ophthalmology, Psychiatry and Neurology, Surgery, Orthopaedic Surgery.

Massachusetts Medical Society headquarters.

The position taken (or not taken) on those bills concerning the medical profession is decided by the Massachusetts Medical Society's Committee on State and National Legislation of which your Legislative Councilor automatically becomes a member. This Committee works hard even though its efforts may not be visible to all of you. Our recent deliberations were published in the February issue of *The Hampden Hippocrat.*

There are usually three meetings of the Council and three meetings of the State Committee, all of which I have attended since April of 1969. Occasionally there are special meetings such as the one on February 28, 1972. At this recent meeting, we decided to support H4999 that establishes a Board to regulate physicians assistants' programs. We also decided to oppose our own bill to set up a medical advisory board for the Mass. Registrar of Motor Vehicles because the chiropractors had it amended so that they would be included.

In the past three years, I have only been asked twice to explain the Society's position, and there has been no disagreement. It is very important that we present a unified position to our legislators. I urge any member who feels we have not acted in your best interests to contact me.

A thread of communication with our legislators has been spun into a rope, but you must take an active part by writing letters to your own legislators or contacting them by phone. It is important that you have your facts and information correct and your local committee will help.

The chief problems to confront us at state level this year are:

(1) the continual encroachment of the cult of chiropractic, as noted in the *American Medical News,* January 24, 1972;

(2) protection of our coronary care nurses in treating cardiac arrest;

(3) membership on health planning councils;

(4) improving techniques in transportation of the injured;

(5) immunity for utilization and peer review committees;

(6) preventing the requirement that you police your own patients as to their ability to drive;

(7) the problem of classifying and regulating "physicians assistants".

On a national level you are best advised to be a member of the AMA and read the *American Medical News,* published weekly. Your Society does support Medicredit and the concept of catastrophic illness coverage. We would like them to be combined in one package and administered through existing insurance companies rather than total socialization administered through a federal bureaucracy, as conceived in the Kennedy plan. America's health bill is now $75,000,000,000 of which we

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account for less than 20%. This figure will continue to increase. The answer to control does not lie in Washington; instead, it is within the framework of a medical foundation which you have just voted. This is a "hot" political issue and we must and will have legislators at state and national levels with whom we can rationalize. This is the job of AMPAC and BAYPAC at election time.

Your local committee has met and concurred with the actions taken at the state level. Each member will personally contact all the legislators representing Hampden District to express and explain our views. The Woman's Auxiliary is coordinating its efforts with ours and I'm sure we will eventually succeed.

James D. Allan, M.D.,
Chairman

MALPRACTICE AND MEDICO-LEGAL AFFAIRS COMMITTEE

The Malpractice and Medico-Legal Affairs Committee has met regularly during the past year and with the help of the members of the Bar Association has gone over several complaints. During the past year also the Medico-Legal Code for Hampden County has been updated and finally an agreement was reached and the final copy has been presented to the Executive Committees respectively of the Bar and of the Hampden District Medical Society.

In conclusion I wish to thank all of the members of the Committee from the Bar Association and Medical Society who have helped me in carrying out this task.

Agostino Natale, M.D.,
Chairman

MEDICAL-RELIGIOUS COMMITTEE

This Committee has had meetings twice during this year. There have been good and interesting discussions among the members of the Committee, especially coming from the clergy.

I have noticed that since Msgr. Russell passed away there has been no replacement nor appointment by the Bishop Christopher Weldon to replace him on the Committee.

The first meeting was held in July, and discussion was centered on the clergys' coverage of an emergency room of a given hospital. The need especially in regard to counselling the patients and helping the physician as part of the total care was discussed. It was recommended to have the Wesson Memorial Hospital as a trial basis with the guidance of Dr. Gary DeN. Hough, III.

At the second meeting in January of 1972, the Committee felt the need for a seminar sponsored by the HDMS on "The Dead and Dying". Not only should this be undertaken on the district level, but also in the individual hospitals, whereby

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HDMS Executive Committee Meetings, May 16 and June 6
MMS Council Meeting, Boston, May 24
MMS Annual Meeting, Boston, May 30, 31, and June 1
American College of Obstetricians and Gynecologists, Chicago, May 1-4
American Psychiatric Association, Dallas, May 1-5
American Society of Clinical Oncology, Boston, May 2 and 3
American Association for Cancer Research, Boston, May 4-6
American Urological Association, Washington, D.C., May 21-25
AMA Annual Meeting, San Francisco, June 18-22

the clergy and the physician and paramedical personnel can have some sort of workshop of this subject. This could be done also as part of the inservice training program of each hospital. Hopefully, this will be brought about in the coming year.

Augusto G. Asinas, M.D.,
Chairman

MEMBERS' INSURANCE COMMITTEE

Your committee faced a crisis at the beginning of the current fiscal year when we were notified by the St. Paul Insurance Company that our Group Business Overhead Insurance Policy was to be canceled as of August 1, 1971. In order to replace this coverage on time, your committee worked through the summer months investigating available group policies from other companies. After careful consideration of various available contracts, your committee determined that the most advantageous one for our society was that administered by the Lester L. Burdick, Inc., who offered us a plan which was in many ways superior to the plan which we had previously with the St. Paul Co. The available coverage was increased from $1,000 per month to $1,500 per month and the duration of coverage was increased from 12 months to 18 months. During the charter enrollment period all members which had been covered under the old St. Paul Policy were to be eligible for replacement in the same amount of the policy in force then, provided they were practicing on a full-time basis. This new Office Overhead Expense Insurance Policy is now in force and has functioned very satisfactorily.

In addition, your committee has instituted a new policy which should be of especial interest to the younger members. This new policy is a disability income insurance program, which provides coverage to the age of 65 years. The old policy remains in effect for a period of ten years, of which the first six years need not be house-confined disability. This policy is also administered by the Lester L. Burdick, Inc. so that a single claim form may be used for either the older or the newer disability income insurance program, plus the Business Overhead Expense Insurance program.

Meanwhile, the personal catastrophe policy, sometimes referred to as "an umbrella policy" and administered by the Field, Eddy, Buckley Co. continues in effect and functions well. This latter policy has been especially valuable in increasing coverage for malpractice insurance over and above the basic malpractice coverage. Your committee recommends this "umbrella policy" as a means of increasing the basic malpractice coverage to $1,000,000.

Meanwhile, our major medical expense insurance program continues to function well. This coverage is not available under the State plan and only a few of the other district societies have this type of coverage. We have been very pleased with the insurance program available to members of HDMS.

H. Bernard Tillman, M.D.,
Chairman

NURSING HOMES COMMITTEE

The Nursing Home Committee held no meetings during 1971. The rapid change in health care during '71 with government controls and regulations forced most of the nursing homes out of the Medicare business. For a while it seemed as though they would have to drop Medicaid patients also, but this has not proved necessary. Unless the Executive

Ernest A. Byron, Jr.

* * * * * *

SPRINGFIELD

Committee has something special in mind, I would suggest the committee be wiped out as serving no needed function.

Frank G. Mills, M.D.,
Chairman

PEER REVIEW REGULAR AND RESERVE COMMITTEES

Inspite of the fact that no aid or encouragement in organizing these two new committees was forthcoming from MMS, President Bandeian urged your chairman to establish an effective Peer Review mechanism within the Hampden District as rapidly as possible. Accordingly, organizational meetings were held during October and November and the objectives and programs of both committees were approved by the Executive Committee as 1971 drew to a close.

An all-out effort to establish reasonable dollar conversion factors for use with the 1971 Massachusetts Relative Value Study was undertaken immediately thereafter, received widespread support from the District membership and was completed successfully in March. The Committees have now begun to act as consultants to physicians, patients and third party payors in judging reasonableness of payments and charges for medical services in the District, effectively relieving the District Grievance Committee of all but ethical complaints.

In the coming year, hopefully with meaningful aid from the MMS Peer Review Committee and new Health Institute, increasing emphasis can be placed on the monitoring of quality and necessity of medical care rendered in the District, both within and outside of the hospital, in addition to fee considerations.

Bruce B. Stoler, M.D.,
Chairman

PUBLIC HEALTH COMMITTEE

In view of the alarming increase in reported cases of infectious syphilis and because gonorrhea in now pandemic in the community the Public Health Committee devoted its entire energies to the problem of venereal disease in the community.

With the cooperation of the local television stations, radio stations and newspapers, our members brought to the attention of the public the problem of venereal disease in this area with special attention given to the availability of free treatment and diagnosis. Special attention was given to the teenager who represents about 9% of the population and who also represents almost 1/4 of the new cases reported. Members of the committee were asked to address school assemblies and our copies of the V.D. films are in constant demand.

The Committee would ask the general membership of the Society to review the treatment dosage schedules for venereal disease and to make your own office a diagnostic center. We would also remind the membership that V.D. is the one disease that does *not* require parental consent for diagnosis and treatment.

John J. Zadworny, M.D.,
Chairman

WOMAN'S AUXILIARY COMMITTEE

Once again the women have demonstrated that they can do a good job without our assistance. The Woman's Auxiliary has had another outstanding year of work and dedication that we should all commend.

They not only work for us but they contribute to the community and are sensitive to its needs. Many of our ancillary groups have received encouragment and financial aid from them and their help to the parent society is known to all.

I know I speak for the entire Society when I say "thank you again, ladies".

Carlo Q. Montori, M.D.,
Chairman

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HIGHLIGHTS OF THE MARCH EXECUTIVE COMMITTEE MEETING

The Executive Committee met on Tuesday, March 21, 1972, in the Society's Conference Room. Present were: Drs. Goldberg, Zacarian, LaMarche, Burke, Moore, Turner, Bandeian, Fisher, McHugh, Gilchriest and Mrs. Purdy. Absent were: Drs. Sheehan, Cummings, and Verrilli.

The meeting was called to order at 8:00 P.M.

Dr. Zacarian read the minutes of the February Executive Committee meeting and these were accepted as read.

Dr. Bandeian introduced Mr. Jack Zinsmeister from the Hampden College of Pharmacy. The latter is planning a new building and the architect's drawing plans were presented to the Committee. It was announced that a dinner meeting is to be held on April 9, 1972, to which all physicians are invited. Dr. Bandeian thanked the men for attending and wished them success in their building campaign.

Dr. James Allan was present as Chairman of BAYPAC. He asked if HDMS would consider inserting a bill for BAYPAC membership along with the mailing of HDMS membership bills when the latter are sent out after May 1, 1972. The Committee voted in the affirmative to mail BAYPAC bills with the Society's dues mailing.

Dr. LaMarche gave a progress report on the Health Care Foundation of Western Massachusetts, Inc. The bylaws are being written and will be presented at the Annual Meeting for a vote.

The Malpractice and Medico-Legal Committee presented the finished Medico-Legal Code for Hampden County for approval.

The Committee approved this code. It will be printed in the April issue of *The Hampden Hippocrat* and voted upon by the membership at the HDMS Annual Meeting.

The meeting was adjourned at 10:30 P.M.

The Grievance Committee met and considered four cases.

The meeting was adjourned at 11:00 P.M.

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In Memoriam

ARTHUR H. STEINHARDT, M.D.

1892 - 1972

Dr. Arthur H. Steinhardt of 357 Gillette Ave., Springfield, died at his home on March 4, 1972.

Born in Wanfried, Germany, on January 3, 1892, Dr. Steinhardt was educated in Germany, where he received his doctorate in medicine from the Georg August University, Goettingen, in 1916. He served in the German Army during World War I and practiced in his native land until 1938, when he came to Springfield to engage in the general practice of medicine.

Dr. Steinhardt served on the medical staff of the Wesson Memorial Hospital for many years. He was a member of the AMA, MMS, HDMS, and the Springfield Academy of Medicine.

To his family, his friends, and associates deepest sympathy is hereby extended.

THE NEXT MEETING of the SPRINGFIELD ACADEMY

will be held on

TUESDAY, MAY 9, 1972

ANNUAL MEETING – ELECTION OF OFFICERS

DINNER: 6:30 P.M.
Storrowton Tavern
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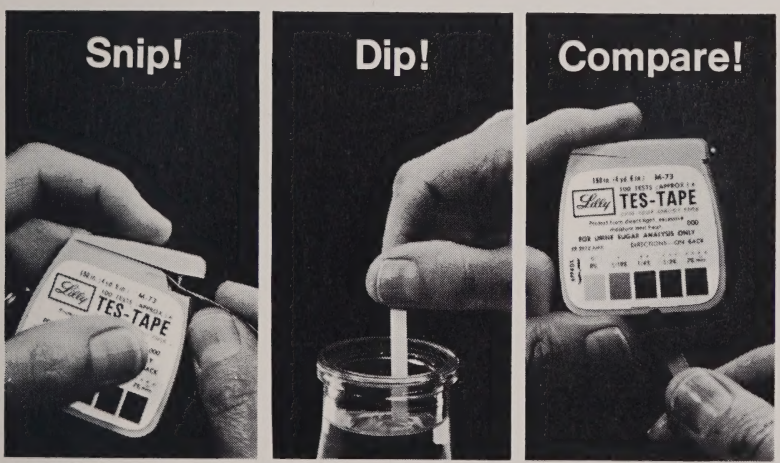

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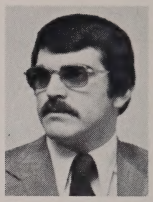

Thomas DeRita, Jr.

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